VERMONT
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

VIVITROL.1
FORM#27
C: 12.14

Agency of Human Services

~VIVITROL~

Prior Authorization Request Form

In order for beneficiaries to receive coverage for Vivitrol, it will be necessary for the prescriber to complete and fax this prior authorization request to Goold Health Systems. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-844-679-5366 or Phone: 1-844-679-5363

Prescribing physician:

Name: _____
Phone#:_____
Fax#: _____
Address: _____
Contact Person at Office: _____

Beneficiary:

Name: _____
Medicaid ID#:_____
Date of Birth: _____ Sex: _____
Pharmacy Name_____
Pharmacy Phone: _____Pharmacy Fax: _____

Administering Physician (Name):_____Address:_____

QUALIFICATIONS

MDs	Prescribers must secure direct delivery of Vivitrol from the pharmacy to the pharmacy to the physician's office. Pharmacies may not dispense Vivitrol directly to the patient. Vivitrol **may not** Be billed through the Medical Benefit as a J-Code J2315

PROCESS

Patient diagnosis/indication for use?	Alcohol dependence	Prevention of relapse to opioid dependency
Has the patient been opiate free for > 7 – 10 days		Yes No
For alcohol dependence: **(1)** Has the patient tried any of the following? Please document below. oral naltrexone: side-effect non-response allergy acamprosate: side-effect non-response allergy disulfiram: side-effect non-response allergy **(2)** Has patient had a recent hospital admission for alcohol detoxification?		 □ Yes □ No □ Yes □ No If yes, date: ____/_____/____
For prevention of relapse to opioid dependency **(1)** Has the patient failed buprenorphine therapy? **(2)** Is the patient not a candidate for buprenorphine therapy? **(3)** Patient requires injectable therapy?		 □ Yes □ No □ Yes □ No □ Yes □ No
Comments and additional patient history:		

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

Prescriber Signature:_____ Date of request:_____

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